Special Olympics Southern California

SPECIAL OLYMPICS SOUTHERN CALIFORNIA

# OFFICIAL SPECIAL OLYMPICS RELEASE FORM

ATHLETE'S NAME_____ SSN:_____ - ____ - _____

## RELEASE TO BE COMPLETED BY ADULT ATHLETE

I, _____ am at least 18 years old and have submitted the attached Application for Participation in Special Olympics. I represent and warrant that, to the best of my knowledge and belief, I am physically and mentally able to participate in Special Olympics activities. I also represent that a licensed physician has reviewed the health information contained in my application and has certified, based on an independent medical examination, that there is no medical evidence which would preclude me from participating in Special Olympics. I understand that if I have Down Syndrome, I cannot participate in sports or events which, by their nature, result in hyper-extension, radical flexion or direct pressure on my neck or upper spine unless I and two physicians have completed the "Special Release for Athletes with Atlanto-axial Instability", available from the Special Olympics Chapter program in my state, or I have had a full radiological examination which establishes the absence of Atlanto-axial Instability. I am aware that if I choose not to complete the "Special Release for Athletes with Atlanto-axial Instability" form, which establishes the absence of Atlanto-axial Instability, I must have the radiological examination before I can participate in equestrian sports, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, and soccer.

Special Olympics has my permission, both during and anytime after, to use my likeness, name, voice, or words in either television, radio, film, newspapers, magazines, and other media, and in any form for the purpose of advertising or communicating the purposes and activities of Special Olympics and/or applying for funds to support these purposes and activities.

If, during my participation in Special Olympics activities, I should need emergency medical treatment, and I am not able to give my consent or make my own arrangements for that treatment because of my injuries, I authorize Special Olympics to take whatever measures are necessary to protect my health and well-being, including, if necessary, hospitalization.

I, the athlete named above, have read this paper and fully understand the provisions of the release that I am signing. I understand that by signing this paper, I am saying that I agree to the provisions of this release.

_____ _____

Signature of Adult Athlete Date

I hereby certify that I have reviewed the release with the athlete whose signature appears above. I am satisfied based on that review, that the athlete understands this release and has agreed to its terms.

Name (Print): _____

Relationship to athlete: _____

(e.g. family member, teacher, coach, etc.)

## RELEASE TO BE COMPLETED BY PARENT OR GUARDIAN OF MINOR ATHLETE

I am the parent/guardian of _____, the minor athlete, on whose behalf I have submitted the attached Application for Participation with Special Olympics. I hereby represent that the athlete has my permission to participate in Special Olympics activities.

I further represent and warrant that to the best of my knowledge and belief, the athlete is physically and mentally able to participate in Special Olympics. With my approval, a licensed physician has reviewed the health information set forth in the athlete's application, and has certified based on an independent medical examination that there is no medical evidence which would preclude the athlete's participation. I understand that if the athlete has Down Syndrome, he/she cannot participate in sports or events which, by their nature, result in hyper-extension, radical flexion or direct pressure on the neck or upper spine, unless I an two physicians have completed the "Special Release for Athletes with Atlanto-axial Instability", available from the Special Olympics Chapter program within my state, or the athlete has had a full radiological examination which establishes the absence of Atlanto-axial Instability. I am aware that if I choose not to complete the "Special Release for Athletes with Atlanto-axial Instability" form, which establishes the absence of Atlanto-axial Instability, the athlete must have the radiological examination before he/she can participate in equestrian sports, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, and soccer.

In permitting that athlete to participate, I am specifically granting my permission, both during and anytime after, to Special Olympics to use the athlete's likeness, name, voice, and words in television, radio, film, newspapers, magazines and other media, and in any form, for the purposes and activities of Special Olympics and/or applying for funds to support those purposes and other activities.

If a medical emergency should arise during that athlete's participation in any Special Olympics activities, at a time when I am not personally present so as to be consulted regarding the athlete's care, I hereby authorize Special Olympics, on my behalf, to take whatever measures are necessary to ensure that the athlete is provided with any emergency medical treatment, including hospitalization, which Special Olympics deems advisable in order to protect that athlete's health and well-being.

I am the parent/guardian of the athlete named in this application. I have read and fully understand the provisions of the above release, and have explained these provisions to the athlete. Through my signature on this release form, I am agreeing to the above provisions on my own behalf and on the behalf of the athlete named above.

I hereby give my permission for the athlete named above to participate in Special Olympics games, recreation programs, and physical activity programs.

_____ _____

Signature of Parent/Guardian Date

Special Olympics Southern California

# APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS

[ ] Check If **NEW** Athlete (Never participated in Special Olympics before)

| CHAPTER OFFICE USE | |
|---|---|
| Received | |
| ID Number | |

June 2004

## SECTION A – ATHLETE HEALTH INFORMATION - *Required initially (new athletes) and every three years for all athletes*

Area _____ Local Program: _____

Athlete Social Security Number: _____ - _____ - _____ Sex/Gender (circle) Male Female

Athlete Name: _____ Date of Birth (month/day/year) _____ / _____ / _____

Address: _____ Home Phone (_____) _____

City: _____ State: _____ Zip: _____

Parent/Guardian Name _____ Work Phone (_____) _____

Address: _____ Home Phone (_____) _____

City: _____ State: _____ Zip: _____

Emergency Contact _____ Home Phone (_____) _____

Health/Accident Company _____ Policy # _____

Ethnic Background (optional) African Amer.→ [ ] Anglo→ [ ] Asian/Pacific Islands→ [ ] Hispanic→ [ ] Native Amer.→ [ ] Other not listed→ [ ] _____

**A physical examination performed by a licensed examiner is required every three (3) years for athletes with YES in items 1-5. An exam is requires the first time NEW is checked in items 6-11.**

| | | Yes | No | | | Yes | No |
|---|---|---|---|---|---|---|---|
| 1. | Heart Disease/Heart Defect/High Blood Pressure | ☐ | ☐ | | 14. Uses a wheelchair | ☐ | ☐ |
| 2. | Chest Pain or Fainting Spells | ☐ | ☐ | | 15. Allergy to the following (be specific) | ☐ | ☐ |
| 3. | Seizures/Epilepsy | ☐ | ☐ | | Medicine _____ | ☐ | ☐ |
| 4. | Diabetes | ☐ | ☐ | | Foods _____ | ☐ | ☐ |
| 5. | Down Syndrome | ☐ | ☐ | | Insect Sting/Bite _____ | ☐ | ☐ |
| | Have cervical spine (neck bone) x-rays been done | ☐ | ☐ | New | 16. Special Diet _____ | ☐ | ☐ |
| | Atlanto Axial Instability | ☐ | ☐ | Problem | 17. Exercise induced wheezing | ☐ | ☐ |
| 6. | Parent/Sibling (under 40) died of heart disease | ☐ | ☐ | ☐ | 18. Tendency to bleed easily | ☐ | ☐ |
| 7. | Absence of vision/blind in one eye | ☐ | ☐ | ☐ | 19. Emotional/psychiatric/behavioral problems | ☐ | ☐ |
| 8. | Absence of one kidney or testicle | ☐ | ☐ | ☐ | 20. Serious bone or joint disorder | ☐ | ☐ |
| 9. | Concussion or serious head injury | ☐ | ☐ | ☐ | 21. Sickle cell trait or disease | ☐ | ☐ |
| 10. | Major surgery or serious illness | ☐ | ☐ | ☐ | 22. Hearing aid/hearing loss | ☐ | ☐ |
| 11. | Heat stroke/exhaustion | ☐ | ☐ | ☐ | 23. Contact lenses/eyeglasses | ☐ | ☐ |
| 12. | Other problem that would interfere with sports participation | ☐ | ☐ | | 24. Dentures/false teeth | ☐ | ☐ |
| | List _____ | | | | 25. Immunizations (shots) are up-to-date | ☐ | ☐ |
| 13. | Impaired motor ability | ☐ | ☐ | | 26. Date of last tetanus shot _____ / _____ / _____ | | |

Comments: _____

Medications – Please print medication name, amount, date prescribed and number of times per day medications needs to be taken

_____

**Signature/Date required** by person completing form (normally parent/guardian or adult athlete).

_____ _____
Signature Date

**Signature/Date required** by adult witness if history signed by Adult Athlete – I have reviewed the health history with the athlete whose signature appears above

_____ _____ _____
Signature Date Relationship to athlete (family member, friends, coach)

IMPORTANT: Any significant change in the athlete's health or condition should be reviewed by a licensed examiner before further participation.

## SECTION B – MEDICAL CERTIFICATION - *Required initially (new athletes) and every three years for athletes with YES in items #1-5*

**EXAMINER'S NOTE:** If the athlete has Down Syndrome, Special Olympics requires a full radiological examination establishing the absence of Atlanto-Axial Instability before he/she may participate in sports or events which, by their nature may result in hyperextension, radical flexion or direct pressure on the neck or upper spine. The sports and events for which such a radiological examination is required are: equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, squat lift, and football team competition (soccer).

BRIEF EXAM: HT _____ WT: _____ PULSE: _____ B.P. _____ ENT: _____ HEART: _____ LUNGS: _____

☐ I have reviewed the above health information and examined the athlete named in the application, and certify there is no medical reason available to me which would preclude the athlete's participation in Special Olympics.

RESTRICTIONS _____

Dr's Signature _____ Date: _____

Dr's Name (Print legibly or stamp) _____ Phone (_____) _____

Address _____ City _____ Zip _____